

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-028679

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

6283

FILED JUL 31 1962

VS 300
Rev. 4/59

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USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH
a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN St. Louis

Length of stay in 1b
39 yrs

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION D O A Homer Phillips Hosp

Inside Limits
Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE b. COUNTY

Missouri

c. CITY OR TOWN St. Louis

Inside Limits
Yes ☐ No ☐

d. STREET ADDRESS 2825 1/2 Easton Ave.

Reside on Farm
Yes ☐ No ☒

3. NAME OF DECEASED
(Type or print)

First Middle Last
HENRY GRANT Jr

4. DATE OF DEATH
Month Day Year
June 22 1962

5. SEX
Male

6. COLOR OR RACE
Col

7. Married ☒ Never Married ☐
Widowed ☐ Divorced ☐

8. DATE OF BIRTH
6-29-22

9. AGE (last birthday)
IF UNDER 1 YEAR IF UNDER 24 HR
Months Days Hours Min.
11 23

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Presser

10b. KIND OF BUSINESS OR INDUSTRY

Dry Cleaning

11. BIRTHPLACE (City and state or country)

St. Louis, Mo

12. CITIZEN OF WHAT COUNTRY

U S A

13a. FATHER'S NAME

Henry Grant Sr

13b. MOTHER'S MAIDEN NAME

Rosa Matthew

14. NAME OF HUSBAND OR WIFE

Rosa Lee Grant

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of serv)

yes WW # 2

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Rosa Lee Grant 2825a Easton Ave

18. CAUSE OF DEATH (Enter only one cause per line)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebral hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

331 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?
YES ☒ NO ☐

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY
Hour a.m. p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 8:05 P.M. to and last saw her/him alive on
Death occurred at m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

Paul J. Simon Deputy Coroner

1300 Clark

6/23/62

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR

6-27-1962

ADDRESS

National

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

JAS H. RANDLE & SON 3133 Bell Ave

JUN 25 1962

Carl Smith M.D.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *Esther N. Harris*

Licensed Embalmer No. *4458*

P. O. Address *4181 Washington*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.